

MARYLAND STATE DEPARTMENT OF HEALTH
1712 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

01696

Reg. Dist. No. 100

Items 13, 14, 15, 16, 17, 18, 19, 20-56 et

1. PLACE OF DEATH - COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltolton</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltolton MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) <u>ANNIE</u> (First) (Middle)				4. DATE OF DEATH <u>2-23-56</u> (Month) (Day) (Year)			
5. SEX <u>F</u>		6. COLOR OR RACE <u>A</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>John Combs New York City</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>4341 Immediate cause (a) <u>Congestive Heart Failure</u></p> <p>Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u></p> <p>(c)</p> </div> <div style="width: 45%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>?</u></p> </div> </div>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>							
SIGNATURE <u>C. Hedden</u> (Degree or title) <u>MD</u>				DATE SIGNED <u>2-26-56</u>			
23. REMOVAL OF REMAINS (Specify)		DATE THEREOF <u>2-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Shilo</u>		LOCATION (City, town, or county) (State) <u>MT Victoria MD</u>	
DATE REC'D BY LOCAL REG. <u>2/27/56</u>		REGISTRAR'S SIGNATURE <u>Quinn H. H. H.</u>		24. FUNERAL DIRECTOR <u>Richard Samuel Home Inc</u>		ADDRESS <u>La Plata MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L. Agnir

Blom

Proprietor of the Hotel

BUREAU V. 2

FEB 29 1956

RECEIVED

William W. L. Blom

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-56 11M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01697

Reg. Dist. No. 100

1713

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>LaPlata Md</u>		<u>8-days</u>		TOWN <u>Indian Head</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hosp. La Plata Md</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John W. Cranford Jr.</u>				<u>2-13-56</u> 19 <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Jan 25-1893</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Indian Head Powder Fac.</u>		<u>Washington, D.C.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John W. Cranford</u>				<u>Martha Fox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Evelyn I. Cranford, Indian Head, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>163X</u> IMMEDIATE CAUSE (A) <u>Carcinoma Left Lung</u>						<u>18-Months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						6-Mths	
<u>Anemia Secondary</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-7-55</u>, 19<u>55</u>, to <u>2-13-56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2-13-56</u>, 19<u>56</u>, and that death occurred at <u>5-35PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>Indian Head Md</u>		<u>2-13-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 16-1956</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>2/15/56</u>		<u>Julia H. Pacey</u>		<u>Sammons Bros</u>			
DATE		ADDRESS					
		<u>1661- Good Hope Road S.E. DC</u>					

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERGYMAN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF SUPERVISOR

20. SIGNATURE OF ASSISTANT SUPERVISOR

21. SIGNATURE OF CLERK

22. SIGNATURE OF RECEPTIONIST

23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF IDENTIFICATION SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

30. SIGNATURE OF ANATOMY

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERGYMAN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF SUPERVISOR

20. SIGNATURE OF ASSISTANT SUPERVISOR

21. SIGNATURE OF CLERK

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23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF IDENTIFICATION SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERGYMAN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

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25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF IDENTIFICATION SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

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28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

RECEIVED
FEB 17 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01698

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1714

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>La Plata</i>				TOWN <i>Waldorf</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physician Memorial</i>				STREET ADDRESS (If rural give location) <i>RT 23-3</i>			
3. NAME OF DECEASED (Type or Print) <i>FRANK HARPER</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Feb. 11, 1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec 17 1896</i>	9. AGE last birthday <i>59</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>US</i>	
13. FATHER'S NAME <i>Thomas Harper</i>				14. MOTHER'S MAIDEN NAME <i>Dora Hawkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>Yes WWI</i>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Harriet Harper Waldorf Md</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <i>Acute Myocardial Failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 Days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic Myocardial Weakness</i>				<i>unknown</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Hypertensive Heart Disease</i>				<i>unknown</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cardio Vascular Failure</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY-street, office-bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 7, 1956</i> , to <i>Feb 11, 1956</i> , that I last saw the deceased alive on <i>Feb 11, 1956</i> , and that death occurred at <i>12:00 PM</i> from the causes and on the date stated above.							
SIGNATURE <i>Robert M. Seron</i>				ADDRESS (Street, city, town, state) <i>Ogeesee Md</i>		DATE SIGNED <i>2/13/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-15-56</i>		NAME OF CEMETERY OR CREMATORY <i>St Peters Cemetery</i>		LOCATION (City, town, or county) (State) <i>Waldorf Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Julia H. Casey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>North Funeral Home</i>		ADDRESS <i>Waldorf Md</i>	
DATE <i>2/15/56</i>							

CERTIFICATE OF DEATH

2574

DEATH NUMBER AND MONTH OF DEATH

PLACE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH

PLACE OF DEATH
 NAME OF PHYSICIAN

NAME OF PHYSICIAN
 NAME OF HOSPITAL

NAME OF HOSPITAL
 NAME OF NURSE

NAME OF NURSE
 NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING PHYSICIAN
 NAME OF HOSPITAL

NAME OF HOSPITAL
 NAME OF NURSE

NAME OF NURSE
 NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING PHYSICIAN
 NAME OF HOSPITAL

NAME OF HOSPITAL
 NAME OF NURSE

NAME OF NURSE
 NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING PHYSICIAN
 NAME OF HOSPITAL

NAME OF HOSPITAL
 NAME OF NURSE

NAME OF NURSE
 NAME OF ATTENDING PHYSICIAN

NOTIFICATION

NOTIFICATION OF DEATH TO BE MADE BY THE PHYSICIAN TO THE LOCAL HEALTH OFFICER, WHO SHALL THEREUPON NOTIFY THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

BUREAU V. S.

FEB 17 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01699

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1715

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>CHAS</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>White Plains</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>White Plains MD.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <i>George</i> (Middle) <i>R</i> (Last) <i>HUNT</i>		4. DATE OF DEATH (Month) <i>2</i> (Day) <i>24</i> (Year) <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>12-20-84</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>71</i> yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>GEORGE A HUNT</i>		14. MOTHER'S MAIDEN NAME <i>JULIA A HUNT</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT & ADDRESS <i>MRS. J. P. RYON WALDORF</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			15. MEDICAL CERTIFICATION
443X IMMEDIATE CAUSE (A) <i>CONGESTIVE HEART FAILURE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2-20-56</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>HYPERTENSIVE HEART DISEASE</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>CIRRHOSIS OF LIVER</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. INJURY OCCURRED		
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 <i>52</i>, to 19 <i>56</i>, that I last saw the deceased alive on <i>2-24-56</i>, and that death occurred at <i>8</i> M, from the causes and on the date stated above.			
SIGNATURE <i>E. J. Jelen</i>		DATE SIGNED <i>2-25-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>LaPlata Md</i>	
DATE THEREOF <i>2-27-56</i>		LOCATION (City, town, or county) <i>Waldorf Md</i>	
24. REC'D BY REGISTRAR <i>3-29-1956</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Thos Hunt Funeral Home Md</i>	
REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>		ADDRESS <i>Waldorf Md</i>	

CERTIFICATE OF DEATH

Charles

White Plains

White Plains
CHAS

George R
M
12-20-84
Huntt
24 25

George A Huntt
Julia A Huntt

Cirrhosis of Liver
Hypertensive Heart Disease
Congestive Heart Failure
Mrs. J. P. Ryan
WARDEN

BUREAU V. S.

FEB 29 1956

RECEIVED

5-5225
25
25

5-5225
25
25

RECEIVED

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01700

1716

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> TOWN <u>La Plata</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Bel Air</u> STREET ADDRESS (If rural give location) <u>Bel Air</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JESSIE</u> (Middle) <u>DARG</u> (Last) <u>JARBOE</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>22</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>US-W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11 Feb 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Chas Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John S. DARG</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE TROTTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Son: James Raman Jarboe, La Plata</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>			<u>5 hrs.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular disease</u>			<u>2 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>about</u> , 19 <u>48</u> , to <u>Feb</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 Feb</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>A. Wooddy</u>		ADDRESS (Street, city, town, state) <u>La Plata, Md.</u> DATE SIGNED <u>22 Feb 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>20 25 56</u>	NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>	LOCATION (City, town, or county) (State) <u>Chapel Point Md.</u>
24. REC'D BY REGISTRAR <u>2/23/56</u>	REGISTRAR'S SIGNATURE <u>Julia H. Paray</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home Inc</u> ADDRESS <u>La Plata Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1717 CERTIFICATE OF DEATH

01701

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN La Plata				TOWN La Plata			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) Ralph. (Middle) M (Last) LORENZ				4. DATE OF DEATH (Month) Feb (Day) 9 (Year) 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12-12-1890	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBER		10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME CHARLES LORENZ				14. MOTHER'S MAIDEN NAME MARY ROSE NEWBERGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Frances Winkler LA PLATA, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
345X IMMEDIATE CAUSE (A) Respiratory Collapse						INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Cardio-vascular Collapse						4 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Sclerosis-disseminated & cutanea.						4 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from June , 19 49 , to 9 Feb , 19 56 , that I last saw the deceased alive on 9 Feb , 19 56 , and that death occurred at 7:20 P.M. , from the causes and on the date stated above.							
SIGNATURE A. Wooddy				ADDRESS (Street, city, town, state) La Plata, Md.		DATE SIGNED 9 Feb 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-13-56		NAME OF CEMETERY OR CREMATORY Sacred Heart		LOCATION (City, town, or county) La Plata, Md.	
24. REC'D BY REGISTRAR DATE 2/10/56		REGISTRAR'S SIGNATURE Julia H. Passy		25. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, La Plata, Md.		ADDRESS	

200702721

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
JAN 14 1966

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - MARTINSBURG, W. VA.

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. RELIGION

10. RACE

11. COLOR

12. HEIGHT

13. WEIGHT

14. BLOOD TYPE

15. SOCIAL SECURITY NUMBER

16. DATE OF DEATH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. MANNER OF DEATH

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESS

22. SIGNATURE OF PHYSICIAN

23. SIGNATURE OF CLERK

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF DISTRICT ATTORNEY

29. SIGNATURE OF COUNTY CLERK

30. SIGNATURE OF TOWNSHIP CLERK

31. SIGNATURE OF VILLAGE CLERK

32. SIGNATURE OF CITY CLERK

33. SIGNATURE OF STATE CLERK

34. SIGNATURE OF FEDERAL CLERK

35. SIGNATURE OF NATIONAL CLERK

36. SIGNATURE OF INTERNATIONAL CLERK

37. SIGNATURE OF COSMOPOLITAN CLERK

38. SIGNATURE OF UNIVERSAL CLERK

39. SIGNATURE OF SUPREMACY CLERK

40. SIGNATURE OF OMNIPOTENCY CLERK

41. SIGNATURE OF INFINITY CLERK

42. SIGNATURE OF ETERNITY CLERK

43. SIGNATURE OF IMMORTALITY CLERK

44. SIGNATURE OF DIVINITY CLERK

45. SIGNATURE OF GODHOOD CLERK

BUREAU OF INVESTIGATION

JAN 14 1966

RECEIVED

1718

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH- COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Chas</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hoghserville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hoghserville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>MAURICE</u> (Middle) <u>F</u> (Last) <u>POWELL</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>8</u> (Year) <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>OCT 21 1910</u>
9. AGE last birthday <u>45</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Herman Powell</u>		14. MOTHER'S MAIDEN NAME <u>Clara Freeman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-14-7550</u>	
17. INFORMANT AND ADDRESS <u>Mrs Dorothy Powell Hoghserville Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4201 Immediate cause (a) <u>CORONARY OCCLUSION</u>		2-8-56	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>R. Deleau</u> (Degree or title) <u>MD</u>		ADDRESS <u>Lafayette Rd</u> DATE SIGNED <u>2-9-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>2-11-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Old Fields Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hoghserville Md</u>	
DATE REC'D BY LOCAL REG <u>2/10/56</u>		REGISTRAR'S SIGNATURE <u>Julia H. Hisey</u>	
24. FUNERAL DIRECTOR <u>Honath Funeral Home</u>		ADDRESS <u>Wheaton</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1956

BUREAU V. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

1719

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01703

Reg. Dist. No. 104 282

1. PLACE OF DEATH: COUNTY <u>Charles Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Wash. D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Cobb Island</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (First) <u>Vir Nira</u> (Middle) <u>FAY</u> (Last) <u>Rountree</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>26</u> (Year) <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct 27 1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>just out of school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	9. AGE last birthday <u>19</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Anty Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Marvin Rountree</u>		14. MOTHER'S MAIDEN NAME <u>Berta Chambers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs Norman Frye 1972 Janell St Wash DC</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

850X Immediate cause (a) Drowning

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.TIME (Month) (Day) (Year) (Hour) OF INJURY 2 26 56 430PLACE (Home, farm, factory, street, office, etc.) OF INJURY Patuxent River Cobb Island Ches. Is.INJURY OCCURRED While at work ☐ Not while at work ☐HOW DID INJURY OCCUR? Boat Capsized

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE C. Rodden

(Degree or title)

ADDRESS La Plata MdDATE SIGNED 2-26-66

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF 3/1/56NAME OF CEMETERY OR CREMATORY St. Leonard CemeteryLOCATION (City, town, or county) Washington D.C.

(State)

DATE REC'D BY LOCAL REG. 29 29 56REGISTRAR'S SIGNATURE John J. Lee24. FUNERAL DIRECTOR Charles J. MattinglyADDRESS Leonardtown, Md

FAY Records

Leaving

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BUREAU V. I.
FAY Records

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01704

1720 **CERTIFICATE OF DEATH**

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>La Plata</u>				TOWN <u>Indian Head</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>BONNIE SUE SHELTON</u>				4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>11</u> (Year) <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>CS-W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>10 Feb 50</u>	
				9. AGE last birthday yrs. <u>—</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>1</u>	
						IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James B. Shelton</u>				14. MOTHER'S MAIDEN NAME <u>Anna May</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Anna May Shelton</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
763.0 IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia, lobar.</u>				<u>36 hrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 Feb</u>, 19 <u>56</u>, to <u>11 Feb</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>11 Feb</u>, 19 <u>56</u>, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wooddy</u> M.D.				ADDRESS (Street, city, town, state) <u>La Plata, Md.</u>		DATE SIGNED <u>11 Feb 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-13-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Pisgah Nazarene Cem.</u>		LOCATION (City, town, or county) (State) <u>Pisgah, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julia H. Passey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u> ADDRESS <u>Waldorf, Md.</u>			
DATE <u>2/13/56</u>							

2066325439

CERTIFICATE OF DEATH

1956

1956

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PLACE OF DEATH

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1956

SHORT SYSTEM

THIS REPORT IS FOR THE USE OF THE HEALTH DEPARTMENT AND IS NOT TO BE DISTRIBUTED OUTSIDE THE DEPARTMENT. IT IS THE PROPERTY OF THE DEPARTMENT AND IS TO BE KEPT IN THE FILES OF THE DEPARTMENT. IT IS NOT TO BE REPRODUCED OR USED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE DEPARTMENT.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1721 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0280604

Reg. Dist. No. 28

1. PLACE OF DEATH- COUNTY Charles CITY (If outside corporate limits, write RURAL and give nearest town) Cobb Island HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY St. Mary's CITY (If outside corporate limits, write RURAL and give nearest town) River Springs STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) LULA (First) KAY (Middle) STAFFORD (Last)		4. DATE OF DEATH Feb. 26 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 8, 1937
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 18 yrs. 18 Months 26 Days 19 Hours 56 Min.
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gordon Stafford		14. MOTHER'S MAIDEN NAME Mildred Rountree	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Gordon Stafford River Springs, Md.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 850X Immediate cause (a) DROWNING Antecedent cause(s) (b) Boat capsize Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2-26-56
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office) Boat River Cobb Island Charles (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY 2 26 02 43		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? Boat capsize	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . SIGNATURE [Signature] (Degree or title) MD ADDRESS La Plata Md DATE SIGNED 2-26-56			
23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify)		DATE THEREOF 3/1/56	
NAME OF CEMETERY OR CREMATORY Secord Hunt		LOCATION (City, town, or county) Bushard, Md (State)	
DATE REC'D BY LOCAL REG. 2-29-56		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR Charles J. Mattingly		ADDRESS Leonardtown, Md	

LILA KAY STAFFORD

DRUMMING

Best copy for

Get from copy John the Mr.
Best copy for

BUREAU V. B.

MAR 1 1956

RECEIVED

01705

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

1722

Reg. Dist. No. 104 782

1. PLACE OF DEATH- COUNTY Charles MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Cobb Island		CITY (If outside corporate limits, write RURAL and give nearest town) River Springs	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) VERNA GLANDA STAFFORD		4. DATE OF DEATH (Month) (Day) (Year) 2 26 56	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH (Month) (Day) (Year) Sept. 24, 1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday (If under 1 year Months Days) (If under 24 hrs. Hours Min.) 15 yrs.
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gordon Stafford		14. MOTHER'S MAIDEN NAME Mildred Rountree	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS Gordon Stafford River Spring, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
850x Immediate cause (a) Drowning	2-26-56
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Protonac River Cobb Island Ches Md	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) OF INJURY 2 26 56	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? Boat Capsized

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ of the body and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE **J. Fedden** (Degree or title) ADDRESS **Lat. Plate No. 2-26-56** DATE SIGNED **2-26-56**

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 3/1/56	NAME OF CEMETERY OR CREMATORY Sacred Heart	LOCATION (City, town, or county) Bethesda, Md.
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DATE REC'D BY LOCAL REG. 2/29/56	REGISTRAR'S SIGNATURE Wm. J. Jones	24. FUNERAL DIRECTOR Charles J. Mattingly	ADDRESS Leonardtown, Md.
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WASH DC 25 MAR 1956

Enclosure

BUREAU V. E.

MAR 1 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1723 **CERTIFICATE OF DEATH**

01706

Reg. Dist. No. 101

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pisgah</i>	LENGTH OF STAY (in this place) <i>40 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pisgah</i>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>William</i> (Middle) <i>Joseph</i> (Last) <i>Thytor</i> TAYLOR		Month <i>Feb.</i> Day <i>9</i> Year <i>19 56</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1-1-82</i>
		9. AGE last birthday <i>74</i> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Powder Factory</i>	11. BIRTHPLACE (State or foreign country) <i>Pomfret, Md</i>
13. FATHER'S NAME <i>Jack Thytor</i> TAYLOR		14. MOTHER'S MAIDEN NAME <i>Elizabeth Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-266513</i>	
		17. INFORMANT & ADDRESS <i>Mrs Wm J. Thytor, Pisgah, Md</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
177X IMMEDIATE CAUSE (A) <i>Metastatic Carcinoma Prostate</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1-3-</i> , 19 <i>56</i> , to <i>2/9</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>2/6</i> , 19 <i>56</i> , and that death occurred at <i>7A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Frank G. Pusey</i> M.D.		ADDRESS (Street, city, town, state) <i>Indian Head, Md</i>	
		DATE SIGNED <i>2-9-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF <i>2/10/56</i>	NAME OF CEMETERY OR CREMATORY <i>Slymont</i>	LOCATION (City, town, or county) (State) <i>Chas Co Md.</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>Mary Southland Johnson</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Johnson</i>	
DATE <i>2-11-56</i>		ADDRESS <i>1702 12th St. Md.</i>	

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death (Print or write full name)

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial place

19. Signature of interment

20. Signature of record

21. Signature of office

22. Signature of department

23. Signature of state

24. Signature of federal

25. Signature of international

26. Signature of universal

27. Signature of world

28. Signature of universe

29. Signature of everything

30. Signature of all

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32. Signature of each

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BUREAU V. 2

FEB 14 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1724 CERTIFICATE OF DEATH

01707

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>2 PLATA</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FENWICK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>66 PH. MEMORIAL HOSP</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>William Rodger Thompson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2-16-56</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept 28, 1881</u>		9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Redland, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward J. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Rabbitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES 1902-1906</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Joe R. Thompson</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) <u>Cardio-Renal Disease</u>						<u>Indefinite</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-Sclerosis-General</u>						<u>Indefinite</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Asthma-Cardiac</u>						<u>Indefinite</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>2-15-54</u> , 19, to <u>2-16-56</u> , 19, that I last saw the deceased alive on <u>2-16-56</u> , 19, and that death occurred at <u>1-20AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews MD.</u> M.D.				ADDRESS (Street, city, town, state) <u>Indian Head Md.</u>		DATE SIGNED <u>2-16-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>BUMPY OAK</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR <u>FEB 21 1956</u>		REGISTRAR'S SIGNATURE <u>F. J. Hall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		ADDRESS <u>WALDOFF Md</u>	

CERTIFICATE OF DEATH

Wm. H. Hall, Jr.

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Nature of disease

9. Duration of disease

10. Name of physician

11. Name of undertaker

12. Name of funeral home

13. Name of cemetery

14. Name of burial place

15. Name of interment

16. Name of registrar

17. Name of witness

18. Name of informant

19. Name of informant

20. Name of informant

21. Name of informant

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75. Name of informant

BUREAU V. S.

FEB 21 1956

RECEIVED

CERTIFICATE

STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

1725

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Cole Island Charles</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Rollin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rollin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rollin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>Russell</u> (Last) <u>Waling</u>	4. DATE OF DEATH <u>2-26-1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>1-1-24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>32</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unk.</u>		14. MOTHER'S MAIDEN NAME <u>unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give day or dates of service) <u>NN #</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>George E. Davis Col Beach</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2-26-56</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
850X Immediate cause (a) <u>Drowning</u>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE OF INJURY <u>Patuxent River Cole Island Ches Md</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) <u>2-26-56 4:30</u>	INJURY OCCURRED <u>Boat Capsized</u>	HOW DID INJURY OCCUR? <u>Boat Capsized</u>
OF INJURY <u>2-26-56 4:30</u>	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Hedden</u>		DATE SIGNED <u>2-26-56</u>	
23. BURIAL INFORMATION	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-28-56</u>	<u>Grace Church</u>	<u>Rollin Fork Va</u>
DATE REC'D BY LOCAL REG. <u>2/27/56</u>	REGISTRAR'S SIGNATURE <u>Julia H. Carey</u>	24. FUNERAL DIRECTOR	ADDRESS
		<u>Bechtel Funeral Home Inc.</u>	<u>La Plata Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Greenway

Gettysburg
1-20-56
1-20-56
1-20-56

RECEIVED

FEB 29 1956

BUREAU V. I.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1726 CERTIFICATE OF DEATH

01709

Reg. Dist. No. 100

Item 9. Film G192 2-20-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Maryland Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bryantown La Plata		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bryantown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED James (First) 2 (Middle) (Last) WASHINGTON				4. DATE OF DEATH 2 9 56			
5. SEX Male		6. COLOR OR RACE col.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 1888	
				9. AGE last birthday 67 66 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Washington				14. MOTHER'S MAIDEN NAME Elizabeth Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Ella A. Washington			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
332x IMMEDIATE CAUSE (A)				Cerebral Thrombosis		2 weeks	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-27-56, to 2-9-56, that I last saw the deceased alive on 2-9-56, and that death occurred at 8:20 A.M. from the causes and on the date stated above.							
SIGNATURE J. M. Johnson M.D.				ADDRESS (Street, city, town, state) La Plata Md		DATE SIGNED 2-10-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-11-56		NAME OF CEMETERY OR CREMATORY Sacred Heart		LOCATION (City, town, or county) (State) La Plata, Md.	
24. REC'D BY REGISTRAR 2/10/56		REGISTRAR'S SIGNATURE Julian H. Pusey		25. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, La Plata, Md.		ADDRESS	

1955 CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL REGISTRAR, MARYLAND DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

County

City or Town

State

Decedent's Name

Age

Sex

Place of Birth

Married

Occupation

Cause of Death

ICD-9

ICD-10

ICD-11

ICD-12

ICD-13

ICD-14

ICD-15

TO

John A. Washington

ICD-9

BUREAU V. B.

FEB 14 1956

RECEIVED

REGISTRATION

100-111-10000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

01710

1727

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Cobb Island "Charles"</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ms</u> COUNTY <u>Shades</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Warrington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u> Peyton</u>	(Middle) <u> C</u>	(Last) <u> Woodzell</u>
4. DATE OF DEATH	(Month) <u> 2</u>	(Day) <u> 26</u>	(Year) <u> 1956</u>
5. SEX <u> Male</u>	6. COLOR OR RACE <u> White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u> Married</u>	8. DATE OF BIRTH <u> Sept 3, 1914</u>
9. AGE last birthday <u> 41</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Merchant</u>	11. BIRTHPLACE (State or foreign country) <u> Warrington Va</u>	12. CITIZEN OF WHAT COUNTRY <u> U.S.A</u>
13. FATHER'S NAME <u> Harry M Woodzell</u>	14. MOTHER'S MAIDEN NAME <u> Alice Risdon</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u> Virginia Savett Warrington Va</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>850X Immediate cause (a) Drowning</u>			INTERVAL BETWEEN ONSET AND DEATH <u> 2-26-56</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> 2-26-56 4:45</u>		INJURY OCCURRED While at <input checked="" type="checkbox"/> work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u> Boat Capsized</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u> C. Rodden</u>		DATE SIGNED <u> 2-26-56</u>	
23. DATE OF REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE REC'D BY LOCAL REG. <u> 2/27/56</u>		REGISTRAR'S SIGNATURE <u> Julia H. Gray</u>	
FUNERAL DIRECTOR <u> Robert Francis Home Inc</u>		ADDRESS <u> Rt. 1, Plata</u>	

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FEB 29 1956

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Gettysburg
and
Liberty

Reg. Dist. No. 100

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1738 CERTIFICATE OF DEATH

1. Name of deceased		2. Usual residence (street or post office)	
3. Date of death		4. Place of death	
5. Age at death		6. Sex	
7. Race		8. Marital status	
9. Occupation		10. Cause of death	
11. Date of burial		12. Place of burial	
13. Name of funeral home		14. Name of physician	
15. Name of undertaker		16. Name of coroner	
17. Name of registrar		18. Name of health officer	
19. Name of medical examiner		20. Name of pathologist	
21. Name of anatomist		22. Name of surgeon	
23. Name of dentist		24. Name of pharmacist	
25. Name of nurse		26. Name of hospital	
27. Name of clinic		28. Name of laboratory	
29. Name of pharmacy		30. Name of dispensary	
31. Name of health department		32. Name of health commission	
33. Name of health council		34. Name of health board	
35. Name of health committee		36. Name of health association	
37. Name of health society		38. Name of health club	
39. Name of health league		40. Name of health union	
41. Name of health alliance		42. Name of health confederation	
43. Name of health federation		44. Name of health congress	
45. Name of health assembly		46. Name of health convention	
47. Name of health conference		48. Name of health meeting	
49. Name of health gathering		50. Name of health event	
51. Name of health occasion		52. Name of health celebration	
53. Name of health festival		54. Name of health fair	
55. Name of health bazaar		56. Name of health picnic	
57. Name of health excursion		58. Name of health trip	
59. Name of health tour		60. Name of health journey	
61. Name of health voyage		62. Name of health cruise	
63. Name of health expedition		64. Name of health excursion	
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67. Name of health excursion		68. Name of health excursion	
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97. Name of health excursion		98. Name of health excursion	
99. Name of health excursion		100. Name of health excursion	

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NOTICE: This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the health officer. It is to be filled out in duplicate, and the original is to be filed in the office of the health officer, and the duplicate is to be filed in the office of the coroner. The certificate is to be filled out in duplicate, and the original is to be filed in the office of the health officer, and the duplicate is to be filed in the office of the coroner. The certificate is to be filled out in duplicate, and the original is to be filed in the office of the health officer, and the duplicate is to be filed in the office of the coroner.